TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
ERIC A VANDERWERFF, DC

**Respondent Name**
LIBERTY INSURANCE CORP.

**MFDR Tracking Number**
M4-17-2662-02

**Carrier's Austin Representative**
Box Number 01

**MFDR Date Received**
May 9, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The physical therapy services . . . were pre-authorized by the carrier (see enclosed pre-authorization letter)"

**Amount in Dispute:** $481.36

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The provider did not request approval for CPT 97112 on his request from 5/3/16. He did receive approval for 6 PT visits with codes 97140 97110 which were paid to the provider on DOS 5/5/16, 5/9/16, 5/11/16, 5/17/16, 5/23/16, and 5/25/16. The denial for DOS 051916 is appropriate as 6 visits were preauthorized and this is the 7th visit"

**Response Submitted by:** Liberty Mutual Insurance

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Dispute Amount | Amount Due |
|---|---|---|---|
| May 9, 2016 to May 25, 2016 | Physical Medicine Procedure Codes: 97112-59-GP, 97140-59-GP, 97110-GP | $481.36 | $155.34 |

## *FINDINGS AND DECISION*

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent. This medical fee dispute is decided pursuant to Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X388 – PRE-AUTHORIZATION WAS REQUESTED BUT DENIED FOR THIS SERVICE PER DWC RULE 134.600.
   - 193 – PRE-AUTHORIZATION WAS REQUESTED BUT DENIED FOR THIS SERVICE PER DWC RULE 134.600.
   - W3 – PRE-AUTHORIZATION WAS REQUESTED BUT DENIED FOR TH
   - X170 – PRE-AUTHORIZATION WAS REQUIRED, BUT NOT REQUESTED FOR THIS SERVICE PER DWC RULE 134.600.
   - U301 – THIS ITEM HAS BEEN REVIEWED ON A PREVIOUSLY SUBMITTED BILL, OR IS CURRENTLY IN PROCESS. NOTIFICATION OF DECISION HAS BEEN PREVIOUSLY PROVIDED OR WILL BE ISSUED UPON COMPLETION OF OUR REVIEW.
   - B13 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - P300 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLEOR CONTRACTED/LEGISLATED FEE ARRANGEMENT.

**Issues**

1. Were the disputed services preauthorized?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - X388 – PRE-AUTHORIZATION WAS REQUESTED BUT DENIED FOR THIS SERVICE PER DWC RULE 134.600.
   - X170 – PRE-AUTHORIZATION WAS REQUIRED, BUT NOT REQUESTED FOR THIS SERVICE PER DWC RULE 134.600.

   The insurance carrier asserts that "The provider did not request approval for CPT 97112 . . . The denial for DOS 051916 is appropriate as 6 visits were preauthorized and this is the 7th visit.

   The requestor asserts that "The physical therapy services . . . were pre-authorized by the carrier (see enclosed pre-authorization letter)"

   Rule §134.600(c) requires that:

   > The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:
   > (1) listed in subsection (p) or (q) of this section only when the following situations occur:
   > (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
   > (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care

   Rule §134.600(p)(5)(A) requires preauthorization for non-emergency physical and occupational therapy services including those listed at HCPCS level I code range for Physical Medicine and Rehabilitation, but limited to:

   (i) Modalities, both supervised and constant attendance;
   (ii) Therapeutic procedures, excluding work hardening and work conditioning;
   (iii) Orthotics/Prosthetics Management;
   (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code

   Review of the submitted preauthorization request from the provider finds that of the disputed services, preauthorization for procedure codes 97140 (Joint Mobilization) and 97110 (Therapeutic Exercises) was requested. No request was found for preauthorization of code 97112 (Neuromuscular Reeducation).

   The provider did request authorization for a similar code, 97012 (Traction), but this code was not billed.

   Review of the utilization management letter approving the authorization (which states approval was based on a provider agreed upon modified treatment plan) finds that procedure code 97112 (Neuromuscular Reeducation) was not listed among the approved services.

   Neuromuscular reeducation (code 97112) is listed in the HCPCS level I code range for physical medicine and rehabilitation therapeutic procedures. Preauthorization was therefore required for non-emergency services under Rule §134.600(p)(5)(A)(ii). No documentation was found to support a medical emergency. In the absence of preauthorization or a documented medical emergency, the insurance carrier's denial reasons are supported. Additional reimbursement cannot be recommended for the services billed under procedure code 97112.

However, authorization was found for procedure codes 97110 and 97140, including a course of 6 sessions of therapy from date of service May 6, 2016 to June 30, 2016.

The respondent argues the carrier has already paid for the 6 visits authorized, including dates of service: May 5, May 9, May 11, May 17, May 23 and May 25, 2016. The respondent asserts "the denial for DOS 051916 is appropriate as 6 visits were preauthorized and this is the 7th visit."

Review of the submitted documentation finds that date of service May 5, 2016 (listed above) is outside the range of authorized dates included in the authorization letter (which were from May 6, 2016 to June 30, 2016). Moreover, no services from May 5, 2016 are in dispute. The approved authorization period was for 6 visits beginning May 6th. Disputed date May 19, 2016 was within the approved date range. The submitted information supports that only five other visits were paid for services performed within that authorized period.

Accordingly, the division concludes the health care provider did not exceed the six authorized visits. The insurance carrier's denial reason is not supported. The services of May 19, 2016 were preauthorized. The carrier is thus liable for the reasonable and necessary medical costs. The services billed under procedure codes 97140 and 97110 for date of service May 19, 2016 will therefore be reviewed for reimbursement in accordance with applicable division rules and fee guidelines.

2. This dispute regards payment of medical services with reimbursement subject to the division's *Medical Fee Guideline for Professional Services*, at 28 Texas Administrative Code §134.203, which requires that to determine the maximum allowable reimbursement (MAR), system participants shall apply Medicare payment policies with minimal modifications as set forth in the rule. Rule §134.203(c) specifies that:

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. . . .

   (2) The conversion factors listed in paragraph (1) . . . shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors. . . .

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the division conversion factor. The applicable division conversion factor for calendar year 2016 is $56.82.

   Reimbursement is calculated as follows:

   - Procedure code **97140**, service date **May 19, 2016**, is a physical medicine procedure paid per Rule §134.203(c). For this code, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.43774. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 1.009 is 0.4036. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.84906 is multiplied by the division conversion factor of $56.82 for a MAR of $48.24. Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does **not** have the highest PE for this date. The PE reduced rate is $36.78.

| **97140** | Work | PE | Malpractice | | | | |
|---|---|---|---|---|---|---|---|
| RVU: | 0.43 | 0.4 | 0.01 | | DWC Conv. | | |
| GPCI: | 1.018 | 1.009 | 0.772 | Sum | Factor | Units | MAR |
| Product: | 0.43774 | 0.4036 | 0.00772 | 0.84906 | $56.82 | 0 | $0.00 |
| 50% PE: | 0.43774 | 0.2018 | 0.00772 | 0.64726 | $56.82 | 1 | $36.78 |
| | | | | | | Total: | $36.78 |

- Procedure code **97110**, service date **May 19, 2016**, is a physical medicine procedure paid per Rule §134.203(c). For this code, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.4581. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.009 is 0.44396. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.01544. The sum of 0.9175 is multiplied by the division conversion factor of $56.82 for a MAR of $52.13. Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code has the highest PE for this date. The first unit is paid at $52.13. 3 additional units paid at the PE reduced rate of $39.52 is $118.56. The total for all 4 units is $170.69.

| **97110** | Work | PE | Malpractice | | | | |
|---|---|---|---|---|---|---|---|
| RVU: | 0.45 | 0.44 | 0.02 | | DWC Conv. | | |
| GPCI: | 1.018 | 1.009 | 0.772 | Sum | Factor | Units | MAR |
| Product: | 0.4581 | 0.44396 | 0.01544 | 0.9175 | $56.82 | 1 | $52.13 |
| 50% PE: | 0.4581 | 0.22198 | 0.01544 | 0.69552 | $56.82 | 3 | $118.56 |
| | | | | | | Total: | $170.69 |

3. The total allowable reimbursement for the disputed services is $207.47. The insurance carrier has paid $52.13, leaving an amount due to the requestor of $155.34. This amount is recommended.

**Conclusion**

The amended findings and decision for this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

The division concludes that additional reimbursement is due. As a result, the amount ordered is $155.34.

***ORDER***

Based on the information submitted by the parties, pursuant to Texas Labor Code §413.031 and §413.019, the Division has determined the requestor is entitled to additional reimbursement for the disputed services. By the authority of the Commissioner of Workers' Compensation granted to MFDR to issue, amend or withdraw medical fee dispute resolution findings, decisions and orders, the respondent is hereby ORDERED to remit to the requestor $155.34 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | Grayson Richardson | July 13, 2017 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.